

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2021	06/30/2022

2. Select Your Facility from the Drop-Down Menu Provided:

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
 4. Cost Report Year 2 (if applicable)
 5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2021	06/30/2022

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

6. Medicaid Provider Number:
 7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
 9. Medicare Provider Number:

Data
000002032A
0
0
110015

B. DSH Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

- | | | | | | | | |
|---|---|---|-----|----|----|-----|----------|
| <p>1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)</p> <p>2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?</p> <p>3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?</p> <p>3a. Was the hospital open as of December 22, 1987?</p> <p>3b. What date did the hospital open?</p> | <table border="1" style="background-color: #d9e1f2; width: 150px; text-align: center;"> <tr> <td>DSH Examination Year (07/01/21 - 06/30/22)</td> </tr> <tr> <td>Yes</td> </tr> </table>
<table border="1" style="width: 150px; text-align: center;"> <tr> <td>No</td> </tr> </table>
<table border="1" style="width: 150px; text-align: center;"> <tr> <td>No</td> </tr> </table>
<table border="1" style="width: 150px; text-align: center;"> <tr> <td>Yes</td> </tr> </table>
<table border="1" style="width: 150px; text-align: center;"> <tr> <td>7/1/1955</td> </tr> </table> | DSH Examination Year (07/01/21 - 06/30/22) | Yes | No | No | Yes | 7/1/1955 |
| DSH Examination Year (07/01/21 - 06/30/22) | | | | | | | |
| Yes | | | | | | | |
| No | | | | | | | |
| No | | | | | | | |
| Yes | | | | | | | |
| 7/1/1955 | | | | | | | |

C. Disclosure of Other Medicaid Payments Received:

- Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022**
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.) \$ 3,561,513
- Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022**
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.) \$ 1,908,279
- Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2021 - 06/30/2022** \$ 5,469,792

Certification:

- Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?
 Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

Answer
Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Carol S. Crews
 Hospital CEO or CFO Signature
 Carol S. Crews
 Hospital CEO or CFO Printed Name

CFO
 Title
 770-836-9745
 Hospital CEO or CFO Telephone Number

1/3/2024
 Date
 ccrews@tanner.org
 Hospital CEO or CFO E-Mail

Contact information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	Carol S. Crews
Title	CFO
Telephone Number	770-836-9745
E-Mail Address	ccrews@tanner.org
Mailing Street Address	705 Dixie Street
Mailing City, State, Zip	Carrollton, GA 30117

Outside Preparer:	
Name	Wilson E. Joiner, III
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bjoiner@draffin-tucker.com

D. General Cost Report Year Information 7/1/2021 - 6/30/2022

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:

7/1/2021 through 6/30/2022		
X		

2. Select Cost Report Year Covered by this Survey (enter "X"):

3. Status of Cost Report Used for this Survey (Should be audited if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	TANNER MEDICAL CENTER-VILLA RICA	Yes	
5. Medicaid Provider Number:	000002032A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110015	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2021 - 06/30/2022)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)	\$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)	\$-
8. Out-of-State DSH Payments (See Note 2)	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 71,653	\$ 547,178	\$618,831
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 857,324	\$ 6,089,387	\$6,946,711
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	\$928,977	\$6,636,565	\$7,565,542
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.71%	8.24%	8.18%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services

15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services

16. Total Medicaid managed care non-claims payments (see question 13 above) received

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2021 - 06/30/2022)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 49,051 (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	\$ -
7. Inpatient Hospital Charity Care Charges	6,506,947
8. Outpatient Hospital Charity Care Charges	9,033,322
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 15,540,269

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$112,595,459.00			\$ 73,594,689	\$ -	\$ -	\$ 39,000,770
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$136,606,835.00	\$412,702,692.00		\$ 89,289,014	\$ 269,750,898	\$ -	\$ 190,269,614
20. Outpatient Services		\$78,349,188.00			\$ 51,210,628	\$ -	\$ 27,138,560
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 249,202,294	\$ 491,051,880	\$ -	\$ 162,883,703	\$ 320,961,526	\$ -	\$ 256,408,945
28. Total Hospital and Non Hospital		Total from Above	\$ 740,254,174	Total from Above	\$ 483,845,229		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	740,254,174	Total Contractual Adj. (G-3 Line 2)	482,783,756
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	1,061,473
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Adjusted Contractual Adjustments				483,845,229
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 50,356,701	\$ -	\$ -	\$ 0.00	\$ 50,356,701	49,789	\$75,117,695.00	\$ 1,011.40
2	03100	INTENSIVE CARE UNIT	\$ 5,885,312	\$ -	\$ -	\$ -	\$ 5,885,312	2,409	\$8,833,297.00	\$ 2,443.05
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 2,771,597	\$ -	\$ -	\$ -	\$ 2,771,597	1,469	\$1,337,477.00	\$ 1,886.72
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 59,013,610	\$ -	\$ -	\$ -	\$ 59,013,610	53,667	\$ 85,288,469	
19		Weighted Average								\$ 1,099.62

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio	
20	09200	Observation (Non-Distinct)	4,616	-	\$ 4,668,622	\$2,320,731.00	\$ 9,236,344.00	\$ 11,557,075	0.403962

Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$11,751,185.00	\$ -	\$ -	\$ 11,751,185	\$8,867,698.00	\$38,038,602.00	\$ 46,906,300	0.250525
22	5200	DELIVERY ROOM & LABOR ROOM	\$4,087,068.00	\$ -	\$ -	\$ 4,087,068	\$3,018,316.00	\$8,500.00	\$ 3,026,816	1.350286
23	5300	ANESTHESIOLOGY	\$14,071.00	\$ -	\$ -	\$ 14,071	\$0.00	\$0.00	\$ -	-
24	5400	RADIOLOGY-DIAGNOSTIC	\$6,929,467.00	\$ -	\$ 6,229	\$ 6,935,696	\$14,284,506.00	\$23,202,755.00	\$ 37,487,261	0.185015
25	5500	RADIOLOGY-THERAPEUTIC	\$6,858,375.00	\$ -	\$ 93,710	\$ 6,952,085	\$12,335,507.00	\$52,607,393.00	\$ 64,942,900	0.107049
26	5600	RADIOISOTOPE	\$757,712.00	\$ -	\$ -	\$ 757,712	\$1,966,023.00	\$6,704,868.00	\$ 8,670,891	0.087386
27	6000	LABORATORY	\$6,075,780.00	\$ -	\$ 2,486	\$ 6,078,266	\$29,782,875.00	\$22,471,023.00	\$ 52,253,898	0.116322
28	6500	RESPIRATORY THERAPY	\$8,391,909.00	\$ -	\$ -	\$ 8,391,909	\$13,041,233.00	\$7,030,324.00	\$ 20,071,557	0.418100
29	6600	PHYSICAL THERAPY	\$453,402.00	\$ -	\$ -	\$ 453,402	\$1,539,217.00	\$324,208.00	\$ 1,863,425	0.243316
30	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$2,316,679.00	\$ -	\$ -	\$ 2,316,679	\$9,390,586.00	\$3,058,320.00	\$ 12,448,906	0.186095

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	7200 IMPL. DEV. CHARGED TO PATIENTS	\$1,508,975.00	\$ -	\$ -	\$ 1,508,975	\$867,235.00	\$5,985,980.00	\$ 6,853,215	0.220185
32	7300 DRUGS CHARGED TO PATIENTS	\$65,853,644.00	\$ -	\$ -	\$ 65,853,644	\$49,271,845.00	\$267,532,503.00	\$ 316,804,348	0.207868
33	7600 PARTIAL HOSPITALIZATION PROGRAM	\$5,765,380.00	\$ -	\$ -	\$ 5,765,380	\$20,064.00	\$12,093,387.00	\$ 12,113,451	0.475949
34	9000 CLINIC	\$3,064,636.00	\$ -	\$ -	\$ 3,064,636	\$39,503.00	\$5,520,483.00	\$ 5,559,986	0.551195
35	9001 VACCINE CLINIC	\$2,810.00	\$ -	\$ -	\$ 2,810	\$0.00	\$0.00	\$ -	-
36	9100 EMERGENCY	\$14,108,823.00	\$ -	\$ -	\$ 14,108,823	\$7,509,427.00	\$39,339,117.00	\$ 46,848,544	0.301158
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 137,939,916	\$ -	\$ 102,425	\$ 138,042,341	\$ 154,254,766	\$ 493,153,807	\$ 647,408,573	
127	Weighted Average								0.220408
128	Sub Totals	\$ 196,953,526	\$ -	\$ 102,425	\$ 197,055,951	\$ 239,543,235	\$ 493,153,807	\$ 732,697,042	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 197,055,951				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient		
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis				
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days					
1	03000 ADULTS & PEDIATRICS	\$ 1,011.40		7,167	4,005	3,532	2,570	2,011	17,274							43.46%	
2	03100 INTENSIVE CARE UNIT	\$ 2,443.05		179	594	229	66	148	1,068							50.64%	
3	03200 CORONARY CARE UNIT	\$ -															
4	03300 BURN INTENSIVE CARE UNIT	\$ -															
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -															
6	03500 OTHER SPECIAL CARE UNIT	\$ -															
7	04000 SUBPROVIDER I	\$ -															
8	04100 SUBPROVIDER II	\$ -															
9	04200 OTHER SUBPROVIDER	\$ -															
10	04300 NURSERY	\$ 1,886.72		47	930	-	104	20	1,081							74.95%	
11		\$ -															
12		\$ -															
13		\$ -															
14		\$ -															
15		\$ -															
16		\$ -															
17		\$ -															
18		\$ -															
			Total Days	7,393	5,529	3,761	2,740	2,179	19,423							40.91%	
19	Total Days per PS&R or Exhibit Detail			7,393	5,529	3,761	2,740	2,179									
20	Unreconciled Days (Explain Variance)			-	-	-	-	-									
21.01	Routine Charges			\$ 11,673,287	\$ 7,235,545	\$ 7,278,298	\$ 4,287,116	\$ 4,128,345	\$ 30,474,246							41.18%	
	Calculated Routine Charge Per Diem			\$ 1,578.96	\$ 1,308.65	\$ 1,935.20	\$ 1,564.64	\$ 1,894.61	\$ 1,568.98								
22	Ancillary Cost Centers (from WIS C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
23	09200 Observation (Non-Distinct)		0.403962	312,937	290,688	178,250	221,433	275,841	944,424	180,347	661,193	195,586	973,314	947,375	\$ 2,117,738	37.03%	
24	5000 OPERATING ROOM		0.250525	531,504	856,272	1,668,253	3,430,956	654,142	2,003,502	715,718	1,219,047	711,607	1,739,927	\$ 3,569,616	\$ 7,509,777	28.98%	
25	5200 DELIVERY ROOM & LABOR ROOM		1.350286	42,187	-	1,562,491	-	3,819	-	486,422	2,331	28,607	-	\$ 2,091,100	\$ 6,150	70.43%	
26	5300 ANESTHESIOLOGY		-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
27	5400 RADIOLOGY-DIAGNOSTIC		0.185015	227,808	466,648	283,971	1,659,305	1,580,585	1,628,458	395,415	687,488	1,548,130	1,962,324	\$ 2,487,779	\$ 4,441,899	28.04%	
28	5500 RADIOLOGY-THERAPEUTIC		0.107049	1,017,077	2,543,414	546,117	3,893,705	1,314,687	4,011,621	493,954	1,170,159	1,254,979	5,664,160	\$ 3,371,836	\$ 11,618,500	34.06%	
29	5600 RADIOISOTOPE		0.087386	146,241	207,858	72,658	158,009	258,509	545,765	60,362	101,748	193,431	382,603	\$ 537,770	\$ 1,013,380	24.66%	
30	6000 LABORATORY		0.116322	2,976,804	1,253,631	2,605,363	3,665,951	3,040,572	1,737,387	1,592,431	1,029,783	2,075,895	3,148,732	\$ 10,215,170	\$ 7,686,752	44.57%	
31	6500 RESPIRATORY THERAPY		0.418100	1,381,390	583,017	699,304	713,260	1,486,664	685,032	485,507	173,896	653,402	677,358	\$ 4,052,865	\$ 2,155,205	37.75%	
32	6600 PHYSICAL THERAPY		0.243316	100,690	2,693	28,713	3,361	218,274	41,682	64,509	13,184	72,513	17,386	\$ 412,186	\$ 60,920	30.34%	
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.186095	488,144	72,045	727,899	462,079	1,021,102	303,284	451,873	107,697	556,615	210,883	\$ 2,689,019	\$ 945,105	35.46%	
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.220185	55,933	-	-	-	114,744	340,186	63,197	250,108	96,875	225,279	\$ 233,874	\$ 590,296	16.77%	
35	7300 DRUGS CHARGED TO PATIENTS		0.207868	3,723,643	10,631,973	3,404,134	5,720,114	3,925,276	23,747,833	2,383,750	5,441,527	6,572,191	13,406,803	\$ 45,541,447	\$ 21,965,000	21.96%	
36	7600 PARTIAL HOSPITALIZATION PROGRAM		0.475949	4,174	809,380	285,778	1,027,781	-	269,446	6,163	633,572	-	102,810	\$ 296,115	\$ 2,740,179	25.91%	
37	9000 CLINIC		0.551195	-	-	-	-	87,989	-	-	101,039	-	82,858	\$ -	\$ 189,028	5.06%	
38	9001 VACCINE CLINIC		-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
39	9100 EMERGENCY		0.301158	804,352	2,017,216	455,967	6,872,426	790,185	2,047,696	379,927	1,314,736	631,580	7,321,854	\$ 2,430,431	\$ 12,252,074	48.71%	
40			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
41			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
42			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
43			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
44			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
45			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
46			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
47			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
48			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
49			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
50			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
51			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
52			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
53			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
54			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
55			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
56			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
57			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
58			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
59			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
60			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%								
													\$	\$									
61																							
62																							
63																							
64																							
65																							
66																							
67																							
68																							
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125																							
126																							
127																							
			\$	11,812,886	\$	19,734,835	\$	12,518,898	\$	27,832,200	\$	14,680,580	\$	38,394,307	\$	7,729,576	\$	12,907,509	\$	10,757,544	\$	29,081,679	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
Totals / Payments													
128 Total Charges (includes organ acquisition from Section J)	\$ 23,486,173	\$ 19,734,835	\$ 19,754,443	\$ 27,832,200	\$ 21,958,878	\$ 38,394,307	\$ 12,016,692	\$ 12,907,509	\$ 14,885,889	\$ 29,081,679	\$ 77,216,185	\$ 98,868,851	30.39%
129 Total Charges per PS&R or Exhibit Detail	\$ 23,486,173	\$ 19,734,835	\$ 19,754,443	\$ 27,832,200	\$ 21,958,878	\$ 38,394,307	\$ 12,016,692	\$ 12,907,509	\$ 14,885,889	\$ 29,081,679			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 10,324,757	\$ 4,315,133	\$ 11,692,412	\$ 6,251,108	\$ 7,160,355	\$ 8,021,690	\$ 5,105,584	\$ 2,992,112	\$ 4,583,496	\$ 6,240,247	\$ 34,283,108	\$ 21,580,043	34.25%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,882,685	\$ 3,678,957			\$ 167,784	\$ 1,030,337					\$ 7,050,469	\$ 4,709,294	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 5,865,476	\$ 5,738,596							\$ 5,865,476	\$ 5,738,596	
134 Private Insurance (including primary and third party liability)	\$ 41,252	\$ 3,058	\$ 100,948	\$ 84,153			\$ 309	\$ 2,496,995	\$ 4,443,476		\$ 2,639,195	\$ 4,530,996	
135 Self-Pay (including Co-Pay and Spend-Down)								\$ 50			\$ -	\$ 50	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 6,923,937	\$ 3,682,015	\$ 5,966,424	\$ 5,822,749									
137 Medicaid Cost Settlement Payments (See Note B)		\$ (83,317)									\$ -	\$ (83,317)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)											\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 5,279,573	\$ 6,373,147	\$ 1,018,055	\$ 138,484			\$ 6,297,628	\$ 6,511,631	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 621,772	\$ 658,254			\$ 621,772	\$ 658,254	
141 Medicare Cross-Over Bad Debt Payments					\$ 11,051	\$ 15,421					\$ 11,051	\$ 15,421	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 243,638	\$ 3,755	\$ 41,477	\$ 54			\$ 285,115	\$ 3,809	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 71,653	\$ 547,178			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 3,400,820	\$ 716,435	\$ 5,725,988	\$ 428,359	\$ 1,458,309	\$ 598,721	\$ 927,285	\$ (2,248,206)	\$ 4,511,843	\$ 5,693,069	\$ 11,512,402	\$ (504,691)	
146 Calculated Payments as a Percentage of Cost	67%	83%	51%	93%	80%	93%	82%	175%	2%	9%	66%	102%	
147 Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					13,988								
148 Percent of cross-over days to total Medicare days from the cost report					27%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,011.40			349							349	
2	03100 INTENSIVE CARE UNIT	\$ 2,443.05			4							4	
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ 1,886.72											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
					Total Days							353	
19	Total Days per PS&R or Exhibit Detail					353							
20	Unreconciled Days (Explain Variance)												
21					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges
21.01					\$ 521,275		\$ -		\$ -		\$ 521,275		\$ 1,476.70
					Calculated Routine Charge Per Diem	\$ 1,476.70		\$ -		\$ -		\$ 1,476.70	
Ancillary Cost Centers (from W/S C) (list below):					Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)	0.403962			7,678	37,783					7,678	37,783	
23	5000 OPERATING ROOM	0.250525			4,198	57,667					4,198	57,667	
24	5200 DELIVERY ROOM & LABOR ROOM	1.350286			5,992	-					5,992	-	
25	5300 ANESTHESIOLOGY	-			-	-					-	-	
26	5400 RADIOLOGY-DIAGNOSTIC	0.185015			41,978	29,561					41,978	29,561	
27	5500 RADIOLOGY-THERAPEUTIC	0.107049			34,878	166,366					34,878	166,366	
28	5600 RADIOISOTOPE	0.087386			4,750	6,638					4,750	6,638	
29	6000 LABORATORY	0.116322			98,892	63,928					98,892	63,928	
30	6500 RESPIRATORY THERAPY	0.418100			24,333	13,549					24,333	13,549	
31	6600 PHYSICAL THERAPY	0.243316			497	1,932					497	1,932	
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.186095			7,753	5,019					7,753	5,019	
33	7200 IMPL. DEV. CHARGED TO PATIENTS	0.220185			2,800	-					2,800	-	
34	7300 DRUGS CHARGED TO PATIENTS	0.207868			100,572	1,209,406					100,572	1,209,406	
35	7600 PARTIAL HOSPITALIZATION PROGRAM	0.475949			-	-					-	-	
36	9000 CLINIC	0.551195			-	9,202					-	9,202	
37	9001 VACCINE CLINIC	-			-	-					-	-	
38	9100 EMERGENCY	0.301158			37,238	148,447					37,238	148,447	
39		-			-	-					-	-	
40		-			-	-					-	-	
41		-			-	-					-	-	
42		-			-	-					-	-	
43		-			-	-					-	-	
44		-			-	-					-	-	
45		-			-	-					-	-	
46		-			-	-					-	-	
47		-			-	-					-	-	
48		-			-	-					-	-	

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 371,560	\$ 1,749,498	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ 892,835	\$ 1,749,498	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 892,835	\$ 1,749,498
129	Total Charges per PS&R or Exhibit Detail	\$ 892,835	\$ 1,749,498	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 442,888	\$ 369,249	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 442,888	\$ 369,249
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 450,981	\$ 175,016							\$ 450,981	\$ 175,016
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									\$ -	\$ -
134	Private Insurance (including primary and third party liability)									\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 23							\$ -	\$ 23
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 450,981	\$ 175,039	\$ -	\$ -						
137	Medicaid Cost Settlement Payments (See Note B)									\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ (8,093)	\$ 194,210	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (8,093)	\$ 194,210
144	Calculated Payments as a Percentage of Cost	102%	47%	0%	0%	0%	0%	0%	0%	102%	47%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (07/01/2021-06/30/2022) TANNER MEDICAL CENTER-VILLA RICA

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 1,765,367	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	9900.85 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 1,765,367	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 1,765,367	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	178,727,369
19 Uninsured Hospital Charges Sec. G	43,967,569
20 Total Hospital Charges Sec. G	732,697,042
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	24.39%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.00%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC	\$ -

* Assessment must exclude any non-hospital assessment such as Nursing Facility.

** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.